BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

UTE SARAH RIVERA-PRATT Claimant	)	
VS.	)	
JUNCTION CITY FT. RILEY TRANSPORTATION Respondent	)	Docket No. 1,035,521
AND	)	
FIRSTCOMP INSURANCE COMPANY Insurance Carrier	)	

ORDER

STATEMENT OF THE CASE

Claimant requested review of the April 19, 2011, Award entered by Administrative Law Judge Rebecca A. Sanders. The Board heard oral argument on July 20, 2011. The Director appointed E.L. Lee Kinch to serve as Appeals Board Member Pro Tem in place of former Board Member Julie A.N. Sample. Jeff K. Cooper, of Topeka, Kansas, appeared for claimant. Michael D. Streit, of Wichita, Kansas, appeared for respondent and its insurance carrier (respondent).

The Administrative Law Judge (ALJ) determined that claimant is not permanently, totally disabled. The ALJ found that claimant had a 10 percent functional impairment.[1] The ALJ further found that claimant was entitled to a work disability of 83 percent based on a 100 percent wage loss and a 66 percent task loss. The ALJ ordered respondent to provide claimant with ongoing pain management medical care and held that any additional future medical treatment would be considered upon proper application.

[1] The ALJ adopted Dr. Do's functional impairment rating. However, Dr. Do's combined rating for the back and the ankle was 14 percent, not 10 percent.

The Board has considered the record and adopted the stipulations listed in the Award.

ISSUES

Claimant asks that the Board find that claimant is permanently, totally disabled. Further, claimant asks the Board to appoint Dr. David S. Sollo as an authorized physician to provide claimant with ongoing medical care and treatment to manage her physical injuries and complex regional pain syndrome (CRPS) condition as well as his referrals, including for psychological treatment, and to authorize Dr. Gregory Meister to perform adjustments to her dorsal column stimulator as needed.

Respondent argues the record shows that claimant retains some capacity for employment in the open labor market and is not permanently, totally disabled. Respondent concedes claimant has a 100 percent wage loss but contends the record shows her task loss to be 49.9 percent based upon the opinion of Dr. Patrick Do. Therefore, respondent contends claimant should be awarded a 75 percent work disability. Although respondent listed an issue of future medical treatment, its brief does not address that issue. Also, respondent listed an issue of credit for an overpayment of temporary total disability benefits. However, it appears respondent was allowed that credit in the computation of the ALJ's award, and that issue need not be addressed by the Board.

The issues for the Board's review are:

(1) What is the nature and extent of claimant's disability? Is claimant permanently, totally disabled?

(2) Is claimant entitled to additional ongoing and future medical treatment to manage her physical and psychological conditions, including her CRPS, and to manage her dorsal column stimulator?

FINDINGS OF FACT

Claimant worked for respondent as a bus monitor, assisting children on and off the bus. On April 26, 2006, she was helping a child off the bus when she stepped into a hole, twisted her right ankle and landed on her right hip. She injured her right ankle, right hip and low back. Claimant was transferred from being a bus monitor to working in the office but continued to work for respondent until October 3, 2007. She left that accommodated work for reasons unrelated to her injury. Later, claimant developed CRPS in her right lower extremity. She has had two surgical procedures on her ankle and sympathetic blocks in her back. She has worn a brace on her right ankle since about a year after the injury for chronic right lateral ankle injury, drop foot and CRPS. She has atrophy of her right lower extremity. A dorsal column stimulator was eventually implanted in her back. At the time

of the regular hearing, claimant was taking morphine sulfate, Gabapentin, Tizanidine, Lortab and Cymbalta for conditions resulting from her accidental injury.

Given claimant's physical condition, she does not believe she is capable of working anywhere. She said she is unable to work because of her CRPS. Also, her permanently implanted stimulator causes her back injury to get irritated so it is hard for her to bend and maneuver. Her back pain goes down her right leg. Standing bothers her because it puts pressure on her lower extremity, and walking is painful. Sitting bothers her. She spends 75 to 80 percent of the day lying down. The medications she takes make her dizzy, light-headed and sleepy, so she cannot regularly drive. The medicine also makes her nauseous, she gets diarrhea and constipation, she has problems with bladder control, and she gets dry mouth.

Claimant said the stimulator helped her CRPS but aggravated her low back injury. She sees Dr. Greg Meister periodically for monitoring of the dorsal column stimulator. She periodically needs adjustments and replacements of her ankle brace. She requires a physician to monitor her medications.

Dr. Patrick Do, a board certified orthopedic surgeon, evaluated claimant two times, both at the request of the ALJ. He first saw claimant on August 20, 2009. She gave him a history of her accident and at that time was complaining of right ankle and foot pain, right hip pain and low back pain. She was walking with an AFO brace. Claimant had undergone two surgical procedures on her ankle performed by Dr. Steven Howell and had developed what was believed to be CRPS.

In his examination, Dr. Do found that claimant was tender when he palpitated her back. She had decreased sensation on the top of her foot. The skin on her right lower extremity was duskier in color than the left, and the right leg was cooler in temperature. She had some right leg atrophy. She ambulated with a very altered gait favoring the right. She had pain in reaction to light sensation of the common peroneal nerve.[2] Dr. Do diagnosed her with back pain, mostly myofascial; status post right ankle surgery times two with what appeared to be residual CRPS. Dr. Do recommended claimant try a dorsal column stimulator, non-narcotic pain medication, anti-inflammatory medication, muscle relaxants, and possibly nerve stabilizing medication. He also recommended non-narcotic pain management.

Dr. Do examined claimant a second time on June 10, 2010, again at the request of the ALJ. She had undergone having a dorsal column stimulator implanted. Claimant told him she thought her stimulator may have helped some but she was still having back pain. She continued to have weakness and pain in her leg. She was still on a lot of medications and still had a right foot drop. Dr. Do performed a physical examination and found claimant

[2] Dr. Do agreed with claimant's attorney that these findings were consistent with CRPS.

was tender on the right paraspinal back area, she had some atrophy in her right leg, and she had some laxity of her ankle. He diagnosed claimant with back pain with signs and symptoms of radiculopathy and status post two right ankle surgeries. Dr. Do's diagnostic impression as of June 10, 2010, did not include CRPS. However, he said it would not surprise him if she still had some component of CRPS. He recommended non-narcotic pain medication, anti-inflammatories, muscle relaxers and continuation of nerve stabilizing medication, monitored by one doctor.

Dr. Do believed claimant was at maximum medical improvement. Based on the AMA *Guides*,[3] he placed her in DRE Lumbosacral Category III, which includes radiculopathy, for a 10 percent permanent partial impairment to the whole body. He rated her ankle laxity from her two previous surgeries as being a 4 percent whole person impairment. These combined for a 14 percent permanent partial impairment to the whole body. Dr. Do said he took into account claimant's CRPS when putting her in Category III and assigning her a 10 percent impairment, saying claimant mostly had myofascial back pain, which would only put her in Category II for a 5 percent impairment. He said the pain going down claimant's leg could be from her back, could be CRPS, or could be from her ankle surgery.

Dr. Do recommended claimant have lifting restrictions of 0 to 10 pounds continuously, 11 to 20 pounds occasionally, and nothing greater than 21 pounds. He recommended claimant restrict bending 90 degrees 0 to 33 percent of the day; standing and walking 34 to 66 percent of the day, and no ladder climbing. Dr. Do reviewed the task list prepared by Mr. Lindahl. Of 28 tasks[4] on the list, he opined that claimant had lost the ability to perform 14.

Dr. Pedro Murati is board certified in rehabilitation and physical medicine and electrodiagnostic medicine and is a board certified independent medical examiner. At the request of claimant's attorney, he met with claimant on two occasions, the first being on February 24, 2010. He reviewed her medical records, took a history, and performed a physical examination. He diagnosed her with status post "[d]ebridement of the peroneus brevis and repair of subluxing peroneal tendons with a fibular grove depending [*sic*] followed by a partial ostomy of the first metatarsal and first cuneiform right ankle,"[5] CRPS of the right lower extremity, and low back sprain. He opined that she was essentially and

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[3] American Medical Association, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are based upon the fourth edition of the *Guides* unless otherwise noted.

[4] There were 29 tasks on the list, but Dr. Do said Task No. 2 would depend on whether the lifting would be occasional up to 20 pounds or frequent up to 20 pounds. Dr. Do gave a yes/no answer to that task. If that task were omitted, Dr. Do's task loss opinion would be 50 percent. If it is included as a "yes," the task loss is 48 percent, as a "no" it is a 51.7 percent task loss opinion.

[5] Murati Depo., Ex. 2 at 4.

realistically unemployable and recommended she apply for Social Security disability. He said her brace should be changed every other year by an orthotist, and she should obtain a muscle stimulator for wasting of her right lower extremity. He also believed she should have a home evaluation and better pain management, physical therapy for her lumbar spine, anti-inflammatory and pain medication as needed, and a trial of Catapress TTS patches for her CRPS.

Dr. Murati saw claimant a second time on August 9, 2010. On her physical examination, Dr. Murati found she had hyporeflexive bilateral lower extremity, which means it was hard for him to get reflexes. He said that claimant had deficits in her entire right lower extremity. Muscle strength testing of the right lower extremity showed she had a three over five, a significant finding. Claimant had tenderness in the low back similar to a strain, but she did not have radiculopathy. She had severe atrophy at the leg and thigh level, which he opined was disuse atrophy caused by her severe case of CRPS. She had a weak and painful right lower extremity which she was trying to favor. Her sacroiliac joint and trochanteric bursa on the right were tender. She had range of motion deficits. She was hyperemic and cold in comparing the right leg to the left and had loss of hair on the right leg. Claimant was unable to ambulate without the AFO brace. He noted claimant had a limp. Dr. Murati said claimant had classic signs of CRPS, including marked atrophy, loss of hair, changes of color, changes in temperature, and loss of range of motion.

Dr. Murati said that claimant's current diagnoses were a direct result of her work-related accident on April 26, 2006. He recommended claimant's AFO brace be changed at least every other year by an orthotist; she have a home evaluation and better chronic pain management; a single point cane for ambulation; physical therapy for her lumbar sprain, as well as anti-inflammatory and pain medication; and a trial of Catapress TTS patches for claimant's CRPS.

Based on the AMA *Guides*, Dr. Murati rated claimant as having a 10 percent whole person impairment for placement of the spinal cord stimulator. He also assigned a 13 percent impairment to the right lower extremity for atrophy of the right calf; a 13 percent impairment to the right lower extremity for atrophy of the right thigh; a 9 percent impairment to the right lower extremity for loss of range of motion of the right ankle; and a 25 percent impairment to the right lower extremity for CRPS. These combine to total 48 percent of the right lower extremity and convert to a 19 percent impairment to the whole person. With the 10 percent to the lumbar spine, claimant's whole person impairments combine for a total of 27 percent.

Dr. Murati again found claimant to be realistically unemployable and said that even if claimant were able to get work, she would have difficulty getting there and would miss many days of work. Some days she would have to stop and go home. The fact that she is on chronic narcotic medication affects her ability to concentrate. Dr. Murati would not recommend that claimant drive under the influence of Hydrocodone. Dr. Murati did not give claimant any physical restrictions because she is unemployable. Dr. Murati reviewed

the task list prepared by Doug Lindahl. Of the 29 tasks on the list, he opined that claimant would be able to perform 1, for a 97 percent task loss.

Dr. Jeanette Salone is board certified in physical medicine and rehabilitation. Claimant was referred to Dr. Salone by respondent for management of her chronic pain and first saw claimant on August 25, 2010.

When Dr. Salone first met with claimant, claimant's injury had occurred in 2006. Claimant had been seen by a foot surgeon in 2007 and underwent a scope of the right ankle and the next year a tendon was repaired in the right foot and ankle. Dr. Salone said claimant developed CRPS along the line. Claimant had a spinal stimulator implanted in November 2009 and then continued as a chronic pain patient. Dr. Salone made some changes to claimant's medication.

Dr. Salone questioned the validity of claimant's limping. Dr. Salone saw claimant on September 22, 2010. On that day, claimant wanted to take two Lortabs but dropped one on the floor. Dr. Salone noted that claimant was able to get out of the examination chair, put weight on her right leg, and pick up the pill. Also, Dr. Salone watched claimant walk down a 300 foot hallway and did not notice excessive limping. But when Dr. Salone asked claimant to go from the chair to the examination bed, claimant hopped and would not put her right foot on the floor.

Dr. Salone next saw claimant on November 17, 2010, at which time claimant told Dr. Salone she would be short on her Lortab because she dropped some down a toilet. She also told Dr. Salone about an accident in which she was involved as the driver of a vehicle that hit a deer and a turkey.

Dr. Salone has not personally spoken with claimant since November 2010. Claimant called her office on December 16, 2010, stating that she went to the emergency room on December 13. Dr. Salone's office checked on the emergency room visit and found claimant was trying to receive a prescription from a pharmacy and said she was out of everything. On January 17, 2011, Dr. Salone's office received medical records from Newton Medical Center showing that claimant had been admitted on January 14 and discharged on January 15, 2011. The diagnosis had been an intentional overuse or overdose of medications. Dr. Salone said the records from Newton Medical Center also revealed that claimant had shown up at the emergency room claiming to be out of medication in September 2008, October 2008 and May 2010. Dr. Salone said she did not feel comfortable giving claimant any prescriptions for either narcotic or nonnarcotic medication and indicated that she would write no additional prescriptions for claimant.

Dr. Salone agreed with the diagnosis of CRPS and believed that claimant's pain was real. That diagnosis remained constant through the last time she saw claimant on November 17, 2010.

Dr. Salone testified she believed claimant could do a little light physical demand level work, so she would put her somewhere between sedentary level and light physical level. She would put a restriction of a maximum lifting of 15 pounds with mostly sitting but allowing some walking.

Dr. Salone recommends that claimant obtain psychiatric treatment. Although she is not willing to provide pain management treatment to claimant, she believes claimant does need treatment for management of her chronic pain.

Doug Lindahl, a vocational rehabilitation counselor, visited with claimant by telephone on August 13, 2010, and August 16, 2010. Mr. Lindahl compiled a list of 29 tasks that claimant performed in the period she was employed after graduation from high school.[6] The information with regard to the physical requirements necessary to perform each task came primarily from claimant. At the time of the telephone interviews, claimant was unemployed and was receiving Social Security disability benefits.

Based on the physical restrictions of Drs. Do and Fluter, Mr. Lindahl was of the opinion that claimant would be able to compete in the open labor market. However, based on the medical reports of Dr. T. A. Moeller[7] and Dr. Murati, he said claimant is not able to compete for work in the open labor market.

PRINCIPLES OF LAW

K.S.A. 2010 Supp. 44-501(a) states in part: "In proceedings under the workers compensation act, the burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends." K.S.A. 2010 Supp. 44-508(g) defines burden of proof as follows: "'Burden of proof' means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record."

K.S.A. 2010 Supp. 44-510h states in part:

> (a) It shall be the duty of the employer to provide the services of a health care provider, and such medical, surgical and hospital treatment, including nursing, medicines, medical and surgical supplies, ambulance, crutches, apparatus and transportation to and from the home of the injured employee to a place outside the community in which such employee resides, and within such community if the director, in the director's discretion, so orders, including transportation expenses

[6] She was only 24 years old at the time of the injury.

[7] Dr. Moeller is a psychologist who performed a Global Assessment of Functioning on claimant. His report was not made a part of the record.

> computed in accordance with subsection (a) of K.S.A. 44-515 and amendments thereto, as may be reasonably necessary to cure and relieve the employee from the effects of the injury.
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> (b)(1) If the director finds, upon application of an injured employee, that the services of the health care provider furnished as provided in subsection (a) and rendered on behalf of the injured employee are not satisfactory, the director may authorize the appointment of some other health care provider. In any such case, the employer shall submit the names of three health care providers who, if possible given the availability of local health care providers, are not associated in practice together. The injured employee may select one from the list who shall be the authorized treating health care provider. If the injured employee is unable to obtain satisfactory services from any of the health care providers submitted by the employer under this paragraph, either party or both parties may request the director to select a treating health care provider.

K.S.A. 44-510j(h) states in part:

> If the employer has knowledge of the injury and refuses or neglects to reasonably provide the services of a health care provider required by this act, the employee may provide the same for such employee, and the employer shall be liable for such expenses subject to the regulations adopted by the director.

K.S.A. 44-510c(a)(2) defines permanent total disability as follows:

> Permanent total disability exists when the employee, on account of the injury, has been rendered completely and permanently incapable of engaging in any type of substantial and gainful employment. Loss of both eyes, both hands, both arms, both feet, or both legs, or any combination thereof, in the absence of proof to the contrary, shall constitute a permanent total disability. Substantially total paralysis or incurable imbecility or insanity, resulting from injury independent of all other causes, shall constitute permanent total disability. In all other cases permanent total disability shall be determined in accordance with the facts.

"In this jurisdiction it is not essential that the duration of disability or incapacity of a workman be established by medical testimony."[8] "A workers compensation claimant's testimony alone is sufficient evidence of the claimant's physical condition."[9]

While the injury suffered by the claimant was not an injury that raised a statutory presumption of permanent total disability under K.S.A. 44-510c(a)(2), the statute provides that in all other cases permanent total disability shall be determined in accordance with the

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[8] *Hardman v. City of Iola*, 219 Kan. 840, 845, 549 P.2d 1013 (1976). Also see *Graft v. Trans World Airlines*, 267 Kan. 854, 863-64, 983 P.2d 258 (1999).

[9] *Hanson*, 28 Kan. App. 2d 92, Syl. ¶ 2, 11 P.3d 1184 (2000), *rev. denied* 270 Kan. 898 (2001).

facts. The determination of the existence, extent and duration of the injured worker's incapacity is left to the trier of fact.[10]

In *Wardlow*[11], the claimant, an ex-truck driver, was physically impaired and lacked transferrable job skills making him essentially unemployable as he was capable of performing only part-time sedentary work.

The court in *Wardlow* looked at all the circumstances surrounding his condition including the serious and permanent nature of the injuries, the extremely limited physical chores he could perform, his lack of training, his being in constant pain and the necessity of constantly changing body positions as being pertinent to the decision whether the claimant was permanently totally disabled.

K.S.A. 44-510e(a) states in part:

> Permanent partial general disability exists when the employee is disabled in a manner which is partial in character and permanent in quality and which is not covered by the schedule in K.S.A. 44-510d and amendments thereto. The extent of permanent partial general disability shall be the extent, expressed as a percentage, to which the employee, in the opinion of the physician, has lost the ability to perform the work tasks that the employee performed in any substantial gainful employment during the fifteen-year period preceding the accident, averaged together with the difference between the average weekly wage the worker was earning at the time of the injury and the average weekly wage the worker is earning after the injury. In any event, the extent of permanent partial general disability shall not be less than the percentage of functional impairment. Functional impairment means the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence and based on the fourth edition of the American Medical Association Guides to the Evaluation of Permanent Impairment, if the impairment is contained therein. An employee shall not be entitled to receive permanent partial general disability compensation in excess of the percentage of functional impairment as long as the employee is engaging in any work for wages equal to 90% or more of the average gross weekly wage that the employee was earning at the time of the injury.

K.S.A. 2010 Supp. 44-510k(a) states:

> At any time after the entry of an award for compensation, the employee may make application for a hearing, in such form as the director may require for the furnishing of medical treatment. Such post-award hearing shall be held by the

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[10] *Boyd v. Yellow Freight Systems, Inc.*, 214 Kan. 797, 522 P.2d 395 (1974).

[11] *Wardlow v. ANR Freight Systems*, 19 Kan. App. 2d 110, 113, 872 P.2d 299 (1993).

> assigned administrative law judge, in any county designated by the administrative law judge, and the judge shall conduct the hearing as provided in K.S.A. 44-523 and amendments thereto. The administrative law judge can make an award for further medical care if the administrative law judge finds that the care is necessary to cure or relieve the effects of the accidental injury which was the subject of the underlying award. No post-award benefits shall be ordered without giving all parties to the award the opportunity to present evidence, including taking testimony on any disputed matters. A finding with regard to a disputed issue shall be subject to a full review by the board under subsection (b) of K.S.A. 44-551 and amendments thereto. Any action of the board pursuant to post-award orders shall be subject to review under K.S.A. 44-556 and amendments thereto.

ANALYSIS

Claimant worked for respondent after the accident until October 3, 2007, and is entitled to a functional disability during that period of time. Dr. Patrick Do rated claimant as having a 14 percent permanent partial impairment to the whole body, and Dr. Pedro Murati rated claimant as having a 27 percent permanent partial impairment to the whole body. The Board finds the rating opinions of both Drs. Do and Murati to be equally credible and determines that claimant has a 20.5 percent functional disability to the body as a whole for the period from the date of accident through October 3, 2007.

Claimant is in constant pain. The dorsal column stimulator implanted in her back restricts her ability to bend and maneuver, as does her low back injury. Her CRPS makes it difficult for claimant to walk and stand. She has weakness and atrophy in her right leg. She has foot drop, which also is an impediment to walking. Sitting bothers her back. She spends much of her day lying down. A need to take breaks to lie down is not something that is readily accommodated in the open labor market.

Claimant has established that she is realistically unemployable and entitled to an award of permanent total disability compensation. At the time of the regular hearing, claimant had been prescribed and was taking morphine sulfate, Gabapentin, Tizanidine, Lortab and Cymbalta. Her use of narcotic pain medications alone would make it difficult for claimant to drive and make it unlikely claimant would be hired in the competitive open labor market. When also taking into account her physical limitations, education and her work history of predominently physically demanding jobs, claimant has no real prospects of engaging in substantial gainful employment.

Pursuant to the recommendations of all three physicians, Drs. Do, Murati and Salone, claimant is in need of an authorized treatment physician to provide ongoing pain management and to monitor her medications. Claimant has been in need of such an authorized treating physician since Dr. Salone stopped serving in that capacity in November or December 2010. The ALJ ordered respondent to provide claimant with pain management medical care in the Award of April 19, 2011. As of the date the Board heard

oral argument in this appeal on July 20, 2011, respondent had yet to name an authorized pain management pysician. This is despite the ALJ's order and despite there being no issue concerning the compensability of this claim. As such, the Board is ordering respondent to authorize the physician requested by claimant, to provide pain management treatment, including his referrals. The Board further authorizes Dr. Gregory Meister to provide treatment for claimant, including monitoring and maintaining the dorsal column stimulator. Finally, pursuant to the recommendation of Dr. Salone, respondent shall designate an authorized treating physician to provide claimant with ongoing psychiatric and/or psychological treatment.

CONCLUSION

(1) Claimant has a 20.5 percent functional disability to the body as a whole for the period from April 26, 2006, through her last day worked, October 3, 2007. Claimant is permanently and totally disabled from and after October 3, 2007.

(2) Claimant is entitled to future medical treatment upon proper application to the Director as well as ongoing medical treatment for her chronic pain and resulting psychological condition. Dr. Gregory Meister is authorized to treat claimant. Claimant shall designate another physician to provide her with pain management and to monitor her medications, which respondent shall authorize and respondent shall designate an authorized treating psychiatrist and/or psychologist for claimant.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge Rebecca A. Sanders dated April 19, 2011, is modified as follows:

Claimant is entitled to 75 weeks of permanent partial disability compensation at the rate of $177.14 per week or $13,285.50 for a 20.5 percent functional disability, followed by 48.38 weeks of temporary total disability compensation at the rate of $177.14 per week or $8,570.03, followed by permanent total disability compensation not to exceed $125,000 for a permanent total general body disability.

As of July 27, 2011, there would be due and owing to the claimant 75 weeks of permanent partial disability compensation at the rate of $177.14 per week in the sum of $13,285.50 for a 20.5 percent functional disability, plus 48.38 weeks of temporary total disability compensation at the rate of $177.14 per week in the sum of $8,570.03, followed by 155.57 weeks of permanent total disability compensation at the rate of $177.14 per week in the sum of $27,557.67, for a total due and owing of $49,413.20, which is ordered paid in one lump sum less amounts previously paid. Thereafter, the remaining balance in the amount of $75,586.80 shall be paid at the rate of $177.14 per week until fully paid or until further order of the Director.

IT IS SO ORDERED.

Dated this _____ day of August, 2011.

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BOARD MEMBER

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BOARD MEMBER

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BOARD MEMBER

c: Jeff K. Cooper, Attorney for Claimant
Michael D. Streit, Attorney for Respondent and its Insurance Carrier
Rebecca A. Sanders, Administrative Law Judge